

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: 01-06	2. STATE Louisiana
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE April 6, 2001	

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN☒ AMENDMENT

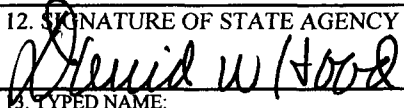
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 447.304	7. FEDERAL BUDGET IMPACT: a. FFY <u>2001</u> <u>\$ 22.48</u> b. FFY <u>2002</u> <u>\$ 47.37</u>
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B, Item 12c, Pages 2,3,4	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Same (TN 00-18)

10. SUBJECT OF AMENDMENT: **The purpose of this amendment is to increase the reimbursement for ostomy supplies. Effective April 6, 2001, ostomy supplies are reimbursed at the lesser of: billed charges; eighty percent (80%) of the Medicare Fee Schedule; or eighty percent (80%) of the Manufacturer's Suggested Retail Price (MSRP).**

11. GOVERNOR'S REVIEW (Check One):


☐ GOVERNOR'S OFFICE REPORTED NO COMMENT☒ OTHER, AS SPECIFIED: **The Governor does not review state plan material.**☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL: 	16. RETURN TO: State of Louisiana Department of Health and Hospitals 1201 Capitol Access Road PO Box 91030 Baton Rouge, LA 70821-9030
13. TYPED NAME: David W. Hood	
14. TITLE: Secretary	
15. DATE SUBMITTED: June 18, 2001	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 29 JUNE 2001	18. DATE APPROVED: 09 July 2001
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PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 06 April 2001	20. SIGNATURE OF REGIONAL OFFICIAL: 
21. TYPED NAME: CALVIN G. CLINE	22. TITLE: ASSOCIATE REGIONAL ADMINISTRATOR DIV OF MEDICAID AND STATE OPERATIONS

23. REMARKS:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

ATTACHMENT 4.19-B
Item 12c, Page 2

STATE OF LOUISIANA

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE OR SERVICES LISTED IN SECTION 1902 (A) OF THE ACT THAT ARE INCLUDED IN THE PROGRAM, UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

ambulatory infusion pumps (to exclude insulin infusion pumps), patient lift slings, percussors, humidifiers, compressors (except for nebulizers with compressors), orthotics and braces and shoes and inserts, and prosthetics are reimbursed at the lesser of :

seventy percent (70%) of the Medicare Fee schedule;
or

billed charges

- C. All DME items identified with HCPC codes beginning with the letter "Z"(except for enteral formulas); miscellaneous equipment items authorized with HCPC code E1399; and home health supply items and other miscellaneous supplies identified with HCPC code Z1399 are reimbursed at seventy percent (70%) of the flat fee schedule (based on 80% of Medicare rate) in effect as of February 7, 2000.

- D. Urological supplies and wound dressings and supplies are reimbursed at the lesser of :

billed charges;

seventy percent (70%) of Medicare Fee Schedule; or

seventy percent (70%) of the Manufacturer's Suggested Retail Price (MSRP).

- E. Ostomy supplies are reimbursed at the lesser of:

billed charges;

eighty percent (80%) of Medicare Fee Schedule; or

eighty percent (80%) of the Manufacturer's Suggested Retail Price (MSRP)

STATE <u>Louisiana</u>	A
DATE REC'D <u>06-29-2001</u>	
DATE APPV'D <u>07-09-2001</u>	
DATE EFF <u>04-06-2001</u>	
HCFA 179 <u>LA-01-06</u>	

TN# 01-06 Approval Date 07-09-2001 Effective Date 04-06-2001
Supersedes
TN# 00-18

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

ATTACHMENT 4.19-B
Item 12c, Page 3

STATE OF LOUISIANA

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE OR SERVICES LISTED IN SECTION 1902 (A) OF THE ACT THAT ARE INCLUDED IN THE PROGRAM, UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

- F. Enteral formulas are reimbursed at the lesser of:
- billed charges; or
- eighty percent (80%) of the Medicare Fee Schedule.
- G. Tracheostomy tubes and care kits are reimbursed at ninety percent (90%) of the Medicare Fee Schedule.
- H. Parenteral and enteral supplies, suction catheters, tracheostomy masks or collars, and tracheostomy cannulas are reimbursed at seventy percent (70%) of the Medicare Fee Schedule.
- I. Enteral infusion pumps, standard type wheelchairs, hospital beds, artificial eyes, commode chairs, and stationary suction machines are reimbursed at the Medicaid established flat fee amount (based on 80% of Medicare rate).
- J. Purchase of oxygen concentrators is reimbursed at eighty three percent (83%) of the flat fee amount (based on Medicare rate) in effect as of February 7, 2000. Rental of oxygen concentrators is reimbursed at eighty five percent (85%) of the flat fee amount (based on Medicare rate) in effect as of February 7, 2000. Purchase of glucometers is reimbursed at thirty percent (30%) of the flat fee amount (based on Medicare rate) in effect as of February 7, 2000.
- K. Another group of equipment is priced on an individual basis. Pricing of this equipment group is based on an item-by-item analysis due to the unique specifications of each item and the beneficiary's needs. These are items which are customized to meet the special medical needs or physical specifications of a particular individual.

Pricing on an item-by-item basis because of unique specifications may include analysis of such factors as invoiced costs to providers, comparative prices of the

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ATTACHMENT 4.19-B
Item 12c, Page 4

STATE OF LOUISIANA

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE OR SERVICES LISTED IN SECTION 1902 (A) OF THE ACT THAT ARE INCLUDED IN THE PROGRAM, UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

providers, manufacturer's suggested retail prices for equipment or system components and negotiated rates based on an accumulation of data from private insurers as to their allowable reimbursement for these types of equipment.

Exception: Reimbursement for customized wheelchairs shall be based on the manufacturer's suggested retail price minus twenty percent (20%) for manual custom wheelchairs and minus seventeen percent (17%) for electric custom wheelchairs.

II. Standards for Payment

- A. Receipt of certification by the physician of proper fit or verification from the beneficiary that the appliance,

equipment and/or supplies have been received and are satisfactory, and

- B. Receipt of the bill from the company in an amount which is in accordance with the established reimbursement methodology.

- C. Approval is based upon the recommendation of the attending physician that the requested item is suitable for use in the home.

- D. Prior authorization is required for Durable Medical Equipment (DME) except intraocular lens implanted during a covered surgery. Authorization is made by the Prior Authorization Unit (PAU) (the extant unit of the former Medical Social Review Team).

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Wound care supplies and dressings, and other medically necessary supply items exclusively designated for use by the home health care agency in the performance of that service are reimbursable under the DME fee schedules.

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